

OTOLARYNGOLOGISTS AND  
OTOLARYNGOLOGY SURGEONS:  
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*Specializing in the treatment of diseases  
of the ear, nose, throat and sinus*

## CONSENT FOR TREATMENT/ PROCEDURE

I give my consent to Dr. \_\_\_\_\_ Jonathan P. Lindman \_\_\_\_\_ to

Excision of skin lesion, with possible full thickness skin graft repair versus local flap repair

(Name of treatment/ procedure. Description in lay & medical terms)

I am aware that, during the procedure, other procedures might be needed. I give my consent to do these procedures as needed.

I give my consent to receive anesthesia and/or medications that I may need. I know that all procedures and anesthetics have risks like stroke, heart attack, respiratory failure and death, but that these are exceedingly rare. The risks of skin lesion removal are minor. These include minor bleeding, infection, pain from the injection of the anesthetic and allergic reaction to the anesthetic, and poor aesthetic results which may require further medical or surgical attention.

Dr Lindman may offer you immediate reconstruction or delayed reconstruction depending on your situation. This may require further surgery.

I know that each person reacts in a different way to treatments and procedures. Therefore, the results cannot be certain. . My questions have been answered about the procedure. I have been told:

1. The treatment or procedure that my doctors plan to do
2. What to expect from the treatment or procedure (the benefits).
3. The serious risks of this treatment or procedure. Some of these risks can happen despite all steps being taken to prevent them.
4. Other types of treatment that could be used. This includes no treatment.
5. Whether or not the treatment or procedure is uncommon.

PATIENT NAME:

Health Care Provider obtaining consent (PRINT NAME & INITIAL) Debbie Driggers, LPN		SIGNATURE of person giving consent (legally authorized to do so)
DATE SIGNED	TIME AM/PM	Relationship to patient (if applicable)
Name of interpreter:		Second witness for telephone consent: